| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *NTAL-126849910* | *State:* | *Arkansas* |
| *Filing Company:* | *National Teachers Associates Life Insurance Company* | *State Tracking Number:* | *47062* |
| *Company Tracking Number:* | *GRD-6004-AR (9/10)* | | |
| *TOI:* | *H11I Individual Health - Disability Income* | *Sub-TOI:* | *H11I.004 Other* |
| *Product Name:* | *Disability Income 4* | | |
| *Project Name/Number:* | */* | | |

## Filing at a Glance

Company: National Teachers Associates Life Insurance Company

| | | |
|---|---|---|
| Product Name: Disability Income 4 | SERFF Tr Num: NTAL-126849910 | State: Arkansas |
| TOI: H11I Individual Health - Disability Income | SERFF Status: Closed-Approved-Closed | State Tr Num: 47062 |
| Sub-TOI: H11I.004 Other | Co Tr Num: GRD-6004-AR (9/10) | State Status: Approved-Closed |
| Filing Type: Form/Rate | | Reviewer(s): Rosalind Minor |
| | Author: Wm. Bradley Cox | Disposition Date: 10/28/2010 |
| | Date Submitted: 10/15/2010 | Disposition Status: Approved-Closed |
| Implementation Date Requested: On Approval | | Implementation Date: |

State Filing Description:

## General Information

| | |
|---|---|
| Project Name: | Status of Filing in Domicile: Authorized |
| Project Number: | Date Approved in Domicile: 09/28/2010 |
| Requested Filing Mode: Review & Approval | Domicile Status Comments: Filed Exempt |
| Explanation for Combination/Other: | Market Type: Individual |
| Submission Type: New Submission | Group Market Size: |
| Overall Rate Impact: | Group Market Type: |
| Filing Status Changed: 10/28/2010 | Explanation for Other Group Market Type: |
| | State Status Changed: 10/28/2010 |
| Deemer Date: | Created By: Wm. Bradley Cox |
| Submitted By: Wm. Bradley Cox | Corresponding Filing Tracking Number: |

Filing Description:

These forms are new and do not replace any previously approved forms.  They will provide benefits for injury, sickness, or hospital confinement and other medical and professional services arising out of total disability as defined in the policy.

The policy will be marketed to individual applicants by independent agents.

These forms were filed “Exempt” by Texas, our domicile, on September 28, 2010.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *NTAL-126849910* | *State:* | *Arkansas* |
| *Filing Company:* | *National Teachers Associates Life Insurance Company* | *State Tracking Number:* | *47062* |
| *Company Tracking Number:* | *GRD-6004-AR (9/10)* | | |
| *TOI:* | *H11I Individual Health - Disability Income* | *Sub-TOI:* | *H11I.004 Other* |
| *Product Name:* | *Disability Income 4* | | |
| *Project Name/Number:* | */* | | |

We also intend to use the referenced application form with our SimpleTerm Life Insurance product, which was approved by your department on July 25, 2010.

Also enclosed is the Actuarial Memorandum with premium rates.

## Company and Contact

**Filing Contact Information**

| | |
|---|---|
| David Mather, Compliance Analyst | david.mather@ntalife.com |
| 4949 Keller Springs Road | 972-532-2133 [Phone]  2577 [Ext] |
| Addison, TX 75001 | 972-532-2194 [FAX] |

**Filing Company Information**

| | | |
|---|---|---|
| National Teachers Associates Life Insurance Company | CoCode: 87963 | State of Domicile: Texas |
| 4949 Keller Springs Road | Group Code: | Company Type: LAH |
| Addison, TX  75001 | Group Name: | State ID Number: |
| (972) 532-2100 ext. [Phone] | FEIN Number: 75-1623431 | |

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## Filing Fees

| | |
|---|---|
| Fee Required? | Yes |
| Fee Amount: | $50.00 |
| Retaliatory? | No |
| Fee Explanation: | |
| Per Company: | No |

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---|---|---|---|
| National Teachers Associates Life Insurance Company | $50.00 | 10/15/2010 | 40784317 |
| National Teachers Associates Life Insurance Company | $100.00 | 10/19/2010 | 40906062 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *NTAL-126849910* | *State:* | *Arkansas* |
| *Filing Company:* | *National Teachers Associates Life Insurance Company* | *State Tracking Number:* | *47062* |
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| *TOI:* | *H11I Individual Health - Disability Income* | *Sub-TOI:* | *H11I.004 Other* |
| *Product Name:* | *Disability Income 4* | | |
| *Project Name/Number:* | */* | | |

# Correspondence Summary

### Dispositions

| Status | Created By | Created On | Date Submitted |
|---|---|---|---|
| Approved-Closed | Rosalind Minor | 10/28/2010 | 10/28/2010 |

### Objection Letters and Response Letters

| Objection Letters | | | | Response Letters | | |
|---|---|---|---|---|---|---|
| **Status** | **Created By** | **Created On** | **Date Submitted** | **Responded By** | **Created On** | **Date Submitted** |
| Pending Industry Response | Rosalind Minor | 10/19/2010 | 10/19/2010 | Wm. Bradley Cox | 10/19/2010 | 10/19/2010 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *NTAL-126849910* | *State:* | *Arkansas* |
| *Filing Company:* | *National Teachers Associates Life Insurance Company* | *State Tracking Number:* | *47062* |
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| *TOI:* | *H11I Individual Health - Disability Income* | *Sub-TOI:* | *H11I.004 Other* |
| *Product Name:* | *Disability Income 4* | | |
| *Project Name/Number:* | */* | | |

# Disposition

Disposition Date: 10/28/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *NTAL-126849910* | *State:* | *Arkansas* |
| *Filing Company:* | *National Teachers Associates Life Insurance Company* | *State Tracking Number:* | *47062* |
| *Company Tracking Number:* | *GRD-6004-AR (9/10)* | | |
| *TOI:* | *H11I Individual Health - Disability Income* | *Sub-TOI:* | *H11I.004 Other* |
| *Product Name:* | *Disability Income 4* | | |
| *Project Name/Number:* | */* | | |

| Schedule | Schedule Item | Schedule Item Status | Public Access |
|---|---|---|---|
| **Supporting Document** | Flesch Certification | Approved-Closed | Yes |
| **Supporting Document** | Application | Approved-Closed | Yes |
| **Supporting Document** | Health - Actuarial Justification | Approved-Closed | No |
| **Supporting Document** | Outline of Coverage | Approved-Closed | Yes |
| **Supporting Document** | Cover Letter | Approved-Closed | Yes |
| **Form** | Disability Income Insurance Policy - Series IV | Approved-Closed | Yes |
| **Form** | Outline of Coverage | Approved-Closed | Yes |
| **Form** | Application for Disability Income and/or SimpleTerm Life Insurance | Approved-Closed | Yes |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *NTAL-126849910* | *State:* | *Arkansas* |
| *Filing Company:* | *National Teachers Associates Life Insurance Company* | *State Tracking Number:* | *47062* |
| *Company Tracking Number:* | *GRD-6004-AR (9/10)* | | |
| *TOI:* | *H11I Individual Health - Disability Income* | *Sub-TOI:* | *H11I.004 Other* |
| *Product Name:* | *Disability Income 4* | | |
| *Project Name/Number:* | */* | | |

# Objection Letter

| | |
|---|---|
| Objection Letter Status | Pending Industry Response |
| Objection Letter Date | 10/19/2010 |
| Submitted Date | 10/19/2010 |
| Respond By Date | |

Dear David Mather,

This will acknowledge receipt of the captioned filing.

Objection 1

- Disability Income Insurance Policy - Series IV, GRD-6004-AR (9/10) (Form)
- Outline of Coverage, GRD-6004-AR.OC (9/10) (Form)
- Application for Disability Income and/or SimpleTerm Life Insurance, 75-401 (9/10) (Form)

Comment: Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is $50.00 per form for a total of $150.00. Please submit an additional $100.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *NTAL-126849910* | *State:* | *Arkansas* |
| *Filing Company:* | *National Teachers Associates Life Insurance Company* | *State Tracking Number:* | *47062* |
| *Company Tracking Number:* | *GRD-6004-AR (9/10)* | | |
| *TOI:* | *H11I Individual Health - Disability Income* | *Sub-TOI:* | *H11I.004 Other* |
| *Product Name:* | *Disability Income 4* | | |
| *Project Name/Number:* | */* | | |

# Response Letter

| | |
|---|---|
| Response Letter Status | Submitted to State |
| Response Letter Date | 10/19/2010 |
| Submitted Date | 10/19/2010 |

Dear Rosalind Minor,

**Comments:**

## Response 1

Comments: Fees have been submitted via EFT.

**Related Objection 1**

Applies To:

- Disability Income Insurance Policy - Series IV, GRD-6004-AR (9/10) (Form)
- Outline of Coverage, GRD-6004-AR.OC (9/10) (Form)
- Application for Disability Income and/or SimpleTerm Life Insurance, 75-401 (9/10) (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is $50.00 per form for a total of $150.00. Please submit an additional $100.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee

**Changed Items:**

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *NTAL-126849910* | *State:* | *Arkansas* |
| *Filing Company:* | *National Teachers Associates Life Insurance Company* | *State Tracking Number:* | *47062* |
| *Company Tracking Number:* | *GRD-6004-AR (9/10)* | | |
| *TOI:* | *H11I Individual Health - Disability Income* | *Sub-TOI:* | *H11I.004 Other* |
| *Product Name:* | *Disability Income 4* | | |
| *Project Name/Number:* | */* | | |

Wm. Bradley Cox

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *NTAL-126849910* | *State:* | *Arkansas* |
| *Filing Company:* | *National Teachers Associates Life Insurance Company* | *State Tracking Number:* | *47062* |
| *Company Tracking Number:* | *GRD-6004-AR (9/10)* | | |
| *TOI:* | *H11I Individual Health - Disability Income* | *Sub-TOI:* | *H11I.004 Other* |
| *Product Name:* | *Disability Income 4* | | |
| *Project Name/Number:* | */* | | |

# Form Schedule

**Lead Form Number:**

| Schedule Item Status | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|---|---|---|---|---|---|---|---|
| Approved-Closed 10/28/2010 | GRD-6004-AR (9/10) | Policy/Contract/Fraternal Certificate | Disability Income Insurance Policy - Series IV | Initial | | 54.000 | GRD-6004-AR (9.10).pdf |
| Approved-Closed 10/28/2010 | GRD-6004-AR.OC (9/10) | Outline of Coverage | Outline of Coverage | Initial | | 50.000 | GRD-6004-AR.OC (9.10).pdf |
| Approved-Closed 10/28/2010 | 75-401 (9/10) | Application/Enrollment Form | Application for Disability Income and/or SimpleTerm Life Insurance | Initial | | 51.000 | 75-401 (9.10).pdf |

# NATIONAL TEACHERS ASSOCIATES LIFE INSURANCE COMPANY

[4949 Keller Springs Road, Addison, Texas 75001● PO Box 802207, Dallas, Texas 75380]
[(888) 671-6771 ● www.ntalife.com]

## DISABILITY INCOME INSURANCE POLICY – SERIES IV

**PLEASE READ THIS POLICY CAREFULLY.**
**THIS POLICY IS A LEGAL CONTRACT BETWEEN THE OWNER AND THE COMPANY.**

**THIS POLICY IS GUARANTEED RENEWABLE FOR LIFE.** This Policy is guaranteed renewable for life if the premiums are paid when due or within the Grace Period. If the premiums are paid on time, we will not cancel the Policy. Renewal premiums will be at the premium rates in effect on each Renewal Date. Premium rates may change, but only if we do so for all policies in the same class.

**NOTICE OF 10-DAY RIGHT TO EXAMINE POLICY.** If the Owner is not satisfied with the Policy for any reason, the Owner may return it to us within 10 days after it is received. Once returned, we will refund the premiums paid, and the Policy will be voided from the original Issue Date.

**IMPORTANT NOTICE! REVIEW THE ATTACHED INSURANCE APPLICATION**. This Policy was issued based on the answers to the questions in the Application (a copy of which is attached to and made a part of this Policy). If there is a misstatement in the Application, or if any information concerning the medical history of the Insured has been omitted, the Owner or Insured must notify us immediately. If any answers on the Application are incomplete, incorrect, or untrue, we may have the right to deny benefits, reform the Policy, or even void the Policy (subject to the "Incontestable" provision and/or applicable laws governing insurance fraud). The best time to clear up any misunderstanding is now, before a claim arises.

**WARNING! WE ARE REQUIRED TO REPORT INSURANCE FRAUD.** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison.

**THIS POLICY CONTAINS A WAITING PERIOD FOR CERTAIN BENEFITS AND AN EXCLUSION FOR PRE-EXISTING CONDITIONS**. Benefits for Sickness are not payable unless the Sickness is First Manifested and First Occurs more than 30 days after the Coverage Effective Date. The Insured is not eligible for Total Disability-Sickness, Hospital Disability, Waiver of Premium or Convalescence benefits attributable to child birth or pregnancy (other than Complications of Pregnancy) if the Total Disability begins during the first 300 days following the Coverage Effective Date. No benefits are payable for a Preexisting Condition during the one year period after the Coverage Effective Date. Please refer to the "Exclusions and Limitations" provision.

**CLAIMS MUST BE FILED WITHIN 12 MONTHS (EXCEPT IN THE ABSENCE OF LEGAL CAPACITY).** No benefits will be payable unless the Proof of Loss for such benefits is filed within 12 months after the covered loss begins. Please refer to the "Claim Provisions-Proof of Loss" provision.

This Policy is signed for us by:

Raymond J Mathys Jr

[President and Chief Executive Officer]

Wm. Bradley Cox

[Vice President and Corporate Secretary]

## NATIONAL TEACHERS ASSOCIATES LIFE INSURANCE COMPANY

## POLICY INDEX



### IMPORTANT NOTICE

To obtain information or make a complaint, you may call or write to
National Teachers Associates Life Insurance Company at:

**National Teachers Associates Life Insurance Company**
P.O. Box 802207
Dallas, Texas 75380
Toll Free 1-888-671-6771
FAX 1-972-532-2194

If we at National Teachers Associates Life fail to provide you with reasonable and adequate service, you should feel free to contact the **Arkansas Insurance Department at:**

**Arkansas Insurance Department**
**Consumer Services Division**
1200 West Third Street
Little Rock, Arkansas 72201
1-501-371-2640
Toll-Free 1-800-852-5494

[Globe] **National Teachers Associates Life Insurance Company** [Bar Code]

**[Date]** **[SAMPLE] SCHEDULE PAGE**

| | | | **Issue** | **Eff/Rev** |
|---|---|---|---|---|
| **Policy Number:** | [**DI23456**] | | | |
| **Insured:** | [JOAN S. DOE] | **Policy Plan Date:** | [1/18/09] | [1/18/09] |
| **Owner:** | [JOAN S. DOE] | **Rider(s) Date:** | [0/0/00 ] | [0/0/00 ] |
| | [123 MAIN STREET] | [Rider Name] | | |
| | [DALLAS, TEXAS 12345] | | | |
| | | **Attachments Exist:** | [Policy Endorsement] | |

**MODE OF PAYMENT:** [Monthly] $[xx.xx]

| FORM | DESCRIPTION | ELIMINATION PERIOD | BENEFIT PERIOD (MAXIMUM) | BENEFIT AMOUNT | ANNUAL PREMIUM |
|---|---|---|---|---|---|
| **GRD-6004 (9/10)** | **DISABILITY INCOME POLICY IV**<br>Occupational Group [I]<br>[75-352 – Important Notice Endorsement] | | | | **$[xxx.xx]** |
| | **PART A BENEFITS-BEFORE AGE 70 IF GAINFULLY EMPLOYED** | | | | |
| | Total Disability-Injury (monthly benefit amount) | **[0] days** | **[6] months** | **$[2,500]** | |
| | Total Disability-Sickness (monthly benefit amount) | **[3] days** | **[6] months** | **$[2,500]** | |
| | Hospital Disability (monthly benefit amount) | **[0] days** | **[6] months** | **$[2,500]** | |
| | Physician Consultation (maximum two visits per calendar year) | | | **$[75]** | |
| | Ambulance (per trip) | | | | |
| | Air Ambulance (maximum two trips per calendar year) | | | **$[1,250]** | |
| | Ground Ambulance (maximum two trips per calendar year) | | | **$[625]** | |
| | Waiver of Premium (after 60 days of continuous Total Disability) | **[60] days** | **[6] months** | | |
| | **PART B BENEFITS-AGE 70 AND THEREAFTER OR WHILE NOT GAINFULLY EMPLOYED** | | | | |
| | Hospital Disability (monthly benefit amount) | **[0] days** | **[6] months** | **$[5,000]** | |
| | Convalescence* (monthly benefit amount) | **[0] days** | **[6] months** | **$[2,500]** | |
| | Physician Consultation (maximum two visits per calendar year) | | | **$[75]** | |
| | Ambulance (per trip) | | | | |
| | Air Ambulance (maximum two trips per calendar year) | | | **$[1,250]** | |
| | Ground Ambulance (maximum two trips per calendar year) | | | **$[625]** | |
| | Waiver of Premium (after 60 days of continuous Hospital Disability) | **[60 days]** | **[6] months** | | |

* Convalescence benefit is payable for the same number of months or part of a month as a covered Hospital Disability is paid.

**Total Annual Premium and Policy Fee (if applicable)** **$[xxx.xx]**
======

## INSURING PROVISION

We agree to pay the benefits provided by this Policy and any attached riders to the Owner, subject to the definitions, provisions, endorsements, exclusions and limitations contained in this Policy, its attached riders, Application, Exclusionary Waiver, or endorsements.

## CONSIDERATION

We have issued this Policy in consideration of the Application and payment of the first premium on or before the Coverage Effective Date. Coverage begins on the Coverage Effective Date at 12:01 a.m. in the time zone where the initial application was signed.

The Policy will remain in force for any period for which the premium is paid when due or during the Grace Period. If the Policy terminates due to nonpayment of premium, it will terminate on the Renewal Date at 12:01 a.m. in the time zone where the initial application was signed (subject to the Grace Period).

## DEFINITIONS

This section provides the meaning of special or capitalized terms used in this Policy.

***Application*** means the application(s) for coverage under this Policy, application(s) for additional benefits, and any application amendment(s). Applications are attached to and made a part of this Policy.

***Benefit Period*** means the maximum length of time for which benefits are payable during any one period of Total Disability or any One Period of Confinement (as applicable). The Benefit Period is shown on the Schedule Page.

After a Total Disability due to Sickness, any subsequent Total Disability due to Sickness that begins within 90 days from the date the prior Total Disability due to Sickness ended will be considered a continuation of the prior Total Disability due to Sickness. Under such circumstances, all determinations of Benefit Periods, Elimination Periods, and whether benefits are payable under Part A or Part B will be combined and made as if the combined Total Disabilities for Sicknesses were one Total Disability. Our liability for the entire combined periods of Total Disability for Sickness will be limited to a single Benefit Period as shown on the Schedule Page.

At any given time, we will only provide benefits for one Total Disability and one maximum Benefit Period, even if the Total Disability may be due to multiple combinations of Sicknesses or Injuries. Therefore, if the Insured is continuously Totally Disabled due, at times, to both a Sickness and Injury (or a number of Sicknesses or Injuries), we will pay, at most, for one Benefit Period.

***Company*** means National Teachers Associates Life Insurance Company.

***Complications of Pregnancy*** means any of the following:

1. Conditions that require Hospital Confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy, but are caused or adversely affected by pregnancy (including preeclampsia, acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical or surgical conditions of an equally serious nature);
2. Non-elective cesarean birth;
3. Ectopic pregnancy that is terminated; or

4. Spontaneous, non-elective termination of a pregnancy that occurs during a period of gestation in which a viable birth is not possible (such as a miscarriage).

Except as specifically listed above, Complications of Pregnancy do not include: false labor; occasional spotting; physician prescribed rest; morning sickness; or similar conditions that may occur in a difficult pregnancy, but do not constitute nosologically distinct complications of a serious nature.

***Coverage Effective Date*** means the later of: (1) the Issue Date; or (2) the date we approve any increase in Policy or rider benefits. The original Coverage Effective Date for the Insured is listed on the Schedule Page.

***Day*** means an overnight stay in a Hospital that is expressly billed by the Hospital: (1) as an inpatient confinement; or (2) on an hourly basis for twenty-four or more continuous hours.

***Exclusionary Waiver*** means an endorsement attached to this Policy which excludes coverage for certain specified conditions based on our underwriting guidelines.

***First Manifested and First Occurs*** means when the earliest of the following takes place:

1. A condition is first diagnosed by a Physician based on generally accepted clinical or laboratory criteria; or
2. Symptoms of a condition are present which would cause an ordinarily prudent person to seek medical advice or treatment, whether or not such medical advice or treatment was actually sought or received.

***Gainful Employment or Gainfully Employed*** means the Insured's status while participating in regular, full-time, active employment in work activity for pay or profit, which involves significant physical and/or mental activities for at least 30 hours per week for a continuous 13 week period. The Company may require evidence of Gainful Employment (employer statements, federal or state tax filings, etc.) as part of the proof of loss.

An Insured is deemed to be no longer Gainfully Employed: (1) after 13 consecutive weeks without regular, full-time, active employment in work activity for pay or profit, which involves significant physical and/or mental activities for at least 30 hours per week; or (2) if the Insured receives retirement benefits under any federal or state sponsored retirement program.

***Grace Period*** means the 31-day period after the Renewal Date. For additional information, refer to the "Grace Period" provision.

***Home Office*** means the primary corporate office of National Teachers Associates Life Insurance Company at PO Box 802207, Dallas, Texas 75380 or such other location designated by us in writing to the Owner.

***Hospital*** means a legally licensed institution that:

1. Provides diagnostic, medical and surgical treatment to sick and injured inpatients (or has such surgical facilities available on a prearranged contractual basis);
2. Provides 24-hour nursing care by or under the supervision of a Nurse; and
3. Is under the supervision of at least one licensed Physician practicing within the scope of his/her license.

Hospital does not include a: hospice; rehabilitation facility; convalescent, nursing or rest home; home for the aged; facility for the care or treatment of drug addiction or alcoholism; hotel units, residential annexes or nurse administered units in or associated with a hospital; or special ward, floor or other accommodation for: (1) convalescent, nursing, rehabilitation, ambulatory or extended care, or (2) the care or treatment of drug addiction or alcoholism.

***Hospital Confined or Hospital Confinement*** means being confined in a Hospital as a registered Inpatient as a result of a covered Injury or Sickness which occurs while this Policy is in force and for which benefits are provided under this Policy.

***Injury*** means an accidental bodily harm that is:

1. Sustained by the Insured;
2. The direct cause of loss (independent of disease, bodily infirmity or any other cause);
3. Caused by an unforeseen external event, which occurs after the Coverage Effective Date and while this Policy is in force; and
4. Not excluded from coverage under any provision of this Policy, the Application, or any endorsement.

All such Injuries sustained in any one event and all complications arising therefrom or recurrences of complications shall be deemed to be a single Injury. A Total Disability resulting from pyrogenic infections incurred through an accidental cut or accidental wound will also be considered an Injury and will be considered as originating from the same cause as the cut or wound for purposes of determining a period of Total Disability.

***Inpatient*** means an Insured who spends a Day of confinement in a Hospital.

***Insured*** means the individual who is insured under this Policy and listed on the Schedule Page as the insured.

***Issue Date*** means the effective date of this Policy shown on the Schedule Page. The Issue Date is not dependent upon the date the Application was signed.

***Nurse*** means a Registered Nurse (R.N.); Licensed Practical Nurse (L.P.N.); or Licensed Vocational Nurse (L.V.N.). Nurse does not include the Insured or the Insured's: spouse, parents, stepparents, in-laws, brothers, sisters, stepbrothers, stepsisters, children, or grandchildren.

***Occupational Group*** means the job-type underwriting classification used for determining premium rates and/or elimination period options. The Occupational Group will appear on the Schedule Page.

***One Period of Confinement*** means: (1) one continuous Hospital Confinement; or (2) two or more separate Hospital Confinements for the same or a related cause that are each separated by less than 30 days.

***Owner*** means the person who is named on the Schedule Page as the owner of the Policy. The Owner has the right to make all changes to the Policy and receive benefits under the Policy (as specified under the "Ownership" provision).

***Physician*** means a medical practitioner who is: (1) duly licensed by the state in which he or she practices medicine; and (2) acting within the scope of his or her medical license. Physician does not include the Insured or the Insured's: spouse, parents, stepparents, in-laws, brothers, sisters, stepbrothers, stepsisters, children, or grandchildren.

***Policy*** means this insurance contract and all riders, endorsements, Exclusionary Waivers, and Applications attached.

***Preexisting Condition*** means a condition (whether known or unknown) for which: (1) medical advice or treatment was recommended by or received from a Physician within the one-year period before the Coverage Effective Date; or (2) symptoms existed within the one-year period before the Coverage Effective Date that would cause an ordinarily prudent person to seek diagnosis, care, or treatment, whether or not such medical advice or treatment was actually sought or received. A Complication of Pregnancy is not considered a Preexisting Condition unless the Total Disability related to the Complication of Pregnancy began before the Coverage Effective Date.

***Renewal Date*** means the date to which premiums are paid for coverage under this Policy (not including the Grace Period). Also, this is the date on which the next premium is due in order to continue this Policy in force.

***Schedule Page*** means the data page attached to this Policy and labeled as such. The Schedule Page is an integral part of this Policy.

***Sickness*** means a disease, disorder, infection, or any other abnormal physical condition that is: (1) not an Injury; (2) not otherwise excluded under the terms of this Policy, Application, an Exclusionary Waiver, rider, endorsement, or amendment; and (3) First Manifested and First Occurs more than 30 days after the Coverage Effective Date. Sickness includes pregnancy (subject to the "Limitations and Exclusions" provision); child birth; Complications of Pregnancy; inguinal, umbilical or post-operative hernia; bacterial infections; diseases or conditions resulting from insect bites; or infestations by microorganisms. Sickness also includes a covered Injury that causes a Total Disability that begins more than 90 days after the date of the Injury.

***Total Disability or Totally Disabled*** means being unable to perform all of the substantial and material duties of the Insured's regular occupation as required by the Insured's employer (if any) and certified by the Insured's Physician. An Insured is deemed Totally Disabled during any period of Hospital Confinement.

***We, us, and our*** (whether or not capitalized) mean National Teachers Associates Life Insurance Company.

***Written Request*** means a request in writing signed by the Owner and acceptable to us. We may require that the Policy be sent in with the written request.

## BENEFITS

**GENERAL CONDITIONS.** All benefits are subject to the definitions, provisions, terms, conditions, limitations, and exclusions (including Exclusionary Waivers) of the Policy, Application, endorsements and attached riders. In order to be payable, any Injury, Sickness, or Hospital Confinement attributable to Total Disability must begin while this Policy is in force for the Insured. We must receive written notice of the Total Disability within 90 days after its commencement and receive written reconfirmation of Total Disability each 30 days thereafter using a form provided by us.

A Total Disability must: (1) commence while this Policy is in force; and (2) require the regular attendance of a Physician (except when the Physician states in writing that care is no longer required because the Insured has reached the lifetime maximum point of recovery). We will consider attendance by a Physician "regular" if we receive evidence of attendance by a Physician at least once every 30 days using a form provided by us. The Physician must confirm that the Insured is unable to perform all of the substantial and material duties of the Insured's regular occupation (if any). The Insured must agree to have a physical examination if we so request.

The benefits amounts and any applicable maximums payable for each benefit are shown on the Policy Schedule Page. (See the definition of "Benefit Period" for limitations of benefits for recurring Sicknesses when periods of Total Disability due to a Sickness are not separated by at least 90 days and for limitations of benefits when there are overlapping periods of Total Disability due, at times, to both Sickness and Injury.)

**PART A BENEFITS – BEFORE AGE 70 IF GAINFULLY EMPLOYED.** We will pay the following benefits if, while Gainfully Employed, the Insured incurs a covered claim before his/her 70th birthday (subject to the terms and conditions described herein). If a Sickness or Injury is First Manifested and First Occurs while the Insured is Gainfully Employed and results in the payment of a Total Disability-Injury or Total Disability-Sickness benefit, we will not terminate the payment of the Total Disability-Injury or a Total Disability-Sickness benefit for the exact same Injury or Sickness solely due to the termination of the Insured's Gainful Employment.

1. **Total Disability-Injury.** We will pay, after the Total Disability-Injury Elimination Period shown on the Schedule Page, the Total Disability-Injury benefit shown on the Schedule Page for each month or part of a month that the Insured is continuously Totally Disabled as a result of a covered Injury. Such Total Disability must begin within 90 days of the date of the covered Injury. This benefit will not be paid beyond the Benefit Period shown on the Schedule Page. The benefit for a part of a month of Total Disability will be paid at the daily rate of 1/30th of the monthly benefit amount.

2. **Total Disability-Sickness.** We will pay, after the Total Disability-Sickness Elimination Period shown on the Schedule Page, the Total Disability-Sickness benefit shown on the Schedule Page for each month or part of a month the Insured is continuously Totally Disabled as a result of a covered Sickness. This benefit will not be paid beyond the Benefit Period shown on the Schedule Page. The benefit for a part of a month of Total Disability will be paid at the daily rate of 1/30th of the monthly benefit amount. Subject to the other provisions contained herein, including the limitation on benefits for Total Disability that begins during the first 300 days after the Coverage Effective Date due to pregnancy other than Complications of Pregnancy, an Insured who delivers a child during or at the end of the third trimester will be deemed Totally Disabled due to Sickness for a period of 45 days, and will receive Total Disability-Sickness benefits for such time less the Elimination Period, unless proof of further Total Disability beyond this time is provided Us.

3. **Hospital Disability.** This benefit is paid in addition to the benefits payable under Part A.1 and A.2 of this Policy. We will pay the Hospital Disability benefit shown on the Schedule Page for each month or part of a month during which the Insured is Hospital Confined due to a covered Sickness or Injury. This benefit is not subject to the Sickness or Injury Elimination Period. This benefit will not be paid beyond the Benefit Period shown on the Schedule Page for each One Period of Confinement. The benefit for a part of a month will be paid at the daily rate of 1/30th of the monthly benefit.

4. **Physician Consultation**. This benefit is paid for an Insured's consultation with a Physician, such as a Physician's office visit, for the purpose of obtaining a diagnosis, treatment, or medical advice. This benefit is payable up to the maximum number of visits per calendar year indicated on the Schedule Page and whether or not Hospital Confined.

5. **Ambulance.** We will pay the applicable Air Ambulance benefit or Ground Ambulance benefit shown on the Schedule Page for up to two one-way trips per calendar year by air ambulance and two one-way trips per calendar year by ground ambulance. Any trip by ambulance must be for the Insured's Injury or Sickness that requires transportation of the Insured by a licensed ambulance to or from a Hospital.

6. **Waiver of Premium.** If the Insured is Totally Disabled as a result of a covered Injury or Sickness for 60 or more consecutive days, we will: (1) waive premiums that become due under this Policy during the Insured's period of Total Disability; and (2) refund the premium paid during the Insured's first 60 days of continuous Total Disability. We will not waive premiums beyond the Benefit Period for a Total Disability-Sickness or Total Disability-Injury (as applicable) shown on the Schedule Page. This Policy and its benefits will continue as though the premium had been paid. After the period of Total Disability ends for which we have waived premium (either due to recovery or reaching the maximum Benefit Period), this Policy may be continued only by the timely payment of premiums as they become due. Any premiums paid during the waiver of premium period will be refunded to the Owner.

**PART B BENEFITS –AGE 70 AND THEREAFTER OR WHILE NOT GAINFULLY EMPLOYED.** We will pay the following benefits if the Insured incurs a covered claim on or after his/her 70th birthday or while not Gainfully Employed (subject to the terms and conditions described herein).

1. **Hospital Disability.** We will pay the Hospital Disability benefit shown on the Schedule Page for each month or part of a month during which the Insured is Hospital Confined due to a covered Sickness or Injury. This benefit is not subject to the Sickness or Injury Elimination Period. This benefit will not be

paid beyond the Benefit Period shown on the Schedule Page for each One Period of Confinement. The benefit for a part of a month will be paid at the daily rate of 1/30th of the monthly benefit.

2. **Convalescence.** We will pay the Convalescence benefit shown on the Schedule Page following a covered Hospital Confinement for which the Insured receives benefits under Part B.1. This benefit will be payable for the same number of months or part of a month that the Hospital Disability benefit is payable. The benefit for a part of a month will be paid at the daily rate of 1/30th of the monthly benefit.

3. **Physician Consultation**. This benefit is paid for an Insured's consultation with a Physician, such as a Physician's office visit, for the purpose of obtaining a diagnosis, treatment, or medical advice. This benefit is payable up to the maximum number of visits per calendar year indicated on the Schedule Page and whether or not Hospital Confined.

4. **Ambulance.** We will pay the applicable Air Ambulance benefit or Ground Ambulance benefit shown on the Schedule Page for up to two one-way trips per calendar year by air ambulance and two one-way trips per calendar year by ground ambulance. Any trip by ambulance must be for the Insured's Injury or Sickness that requires transportation of the Insured by a licensed ambulance to or from a Hospital.

5. **Waiver of Premium.** If the Insured is Hospital Confined and provided with benefits under Part B.1. (Hospital Disability) as a result of an Injury or Sickness for 60 or more consecutive Days, we will: (1) waive premiums that become due under this Policy during the Insured's period of Hospital Confinement; and (2) refund the premium paid during the Insured's first 60 Days of continuous Hospital Confinement. We will not waive premiums beyond the Benefit Period for a Hospital Confinement shown on the Schedule Page. This Policy and its benefits will continue as though the premium had been paid. After the period of Hospital Confinement ends for which we have waived premium (either due to recovery or reaching the maximum Benefit Period), this Policy may be continued only by the timely payment of premiums as they become due. Any premiums paid during the waiver of premium period will be refunded to the Owner.

## Exclusions and Limitations

**GENERAL**. This Policy provides benefits only for loss resulting from: (1) a covered Injury which occurs on or after the Coverage Effective Date and while this Policy is in force; or (2) covered Sickness which is First Manifested and First Occurs more than 30 days after the Coverage Effective Date and while this Policy is in force.

This Policy does not provide benefits for loss if the Injury or Sickness is caused or contributed to by:

1. Preexisting Conditions (to the extent described below);
2. Attempted suicide or intentionally self-inflicted injury (while sane or insane);
3. War or any act of war (whether declared or undeclared);
4. Participation in a riot or civil commotion;
5. Active duty status in the armed forces (if we are notified of such active duty, the Policy will lapse and we will refund any premiums paid for any period for which no coverage is provided as a result of this exclusion);
6. The voluntary use or taking of any narcotic, barbiturate, controlled substance, or other drug (unless prescribed to the individual and taken as directed by a physician); or the medical treatment of these acts;
7. The voluntary taking, absorption, or inhalation of any poison, gas, or fumes; or the medical treatment of any of these acts;
8. Injury resulting from alcohol, an intoxicant, or being under the influence of alcohol or an intoxicant;

9. Injury while the Insured is acting as a pilot or crew member in any aircraft; while a passenger in aircraft operated by the armed forces or used for training, practice, tests, experiment, exhibition or stunt purposes; or while a passenger (other than a fare-paying passenger) in any aircraft;
10. The commission or attempted commission of an assault, battery and/or felony; or being engaged in an illegal occupation;
11. Incarceration in a municipal, county, state or federal correctional facility; or
12. Medical treatment or elective procedure that is not medically necessary, including, but not limited to, cosmetic surgery.

Additionally, the Insured is not eligible for Total Disability-Sickness, Hospital Disability, Waiver of Premium or Convalescence benefits attributable to child birth or pregnancy (other than Complications of Pregnancy) if the Total Disability begins during the first 300 days following the Coverage Effective Date.

**We will not pay concurrent benefits for multiple Injuries or Sicknesses which occur at the same time during a Total Disability.**

**PREEXISTING CONDITIONS.** This Policy and any riders attached to the Policy do not cover Preexisting Conditions for the Insured for the one year period after the Coverage Effective Date. If the Owner requests and we approve a modification of this Policy that increases Policy or rider benefits, the increase in benefits will not cover Preexisting Conditions for the Insured for a one year period after the Coverage Effective Date of such increase in benefits. Persons or conditions excluded in the Application are never covered unless there is an amendment attached to this Policy that waives the exclusion.

## PREMIUMS

**PAYMENT OF PREMIUM.** The first premium is due on the Issue Date. This Policy may be continued to the next Renewal Date by timely payment of premiums. All premiums are to be paid to us. Premiums are due on the last day of the term for which the most recent premium was paid. The premiums for this Policy may change, as stated in the "Renewal Premiums" provision.

**RENEWAL PREMIUMS.** Renewal premiums will be at the rates in effect on each Renewal Date. We may change the premium for this Policy. If we do change the premium rates, we will do so only if we change the premium rates for all policies of this same form and premium classification issued in the same state as this Policy. Premium classification is determined by: issue age; Occupational Group; underwriting classifications; type and level of benefits; and payment method. We will notify the Owner in writing at the Owner's last known mailing address at least 31 days before the change becomes effective.

**REFUND OF PREPAID PREMIUMS.** After the death of the Insured, we will refund prepaid premiums to the Owner for any period beyond the end of the Policy month in which the death occurred if we are provided: (1) written notice; and (2) proper evidence of the death. It is the duty of the Owner, executor or administrator of the estate of the Insured, or their designee, to provide us with prompt notice of the death of the Insured.

## TERMINATION OF COVERAGE

**TERMINATION OF POLICY.** This Policy will terminate and coverage will end for the Insured on the earliest of:

1. The end of the Policy premium paying month immediately following the Owner's request to cancel this Policy;
2. The Renewal Date if the required premium is not paid when due (subject to the Grace Period); or

3. The date of the Insured's death.

Notwithstanding the termination of the Policy, covered benefits beginning while this Policy is in force will be paid for a period not to exceed the duration of the applicable Benefit Period, less any premium then due and unpaid.

**GRACE PERIOD.** This Policy has a 31-day Grace Period. This means that if a premium is not paid on or before the Renewal Date, it may be paid during the 31 days following the Renewal Date. During the Grace Period, this Policy will remain in force. If a benefit is paid during the Grace Period, we may offset the benefit amount otherwise payable by the amount of premium due.

**REINSTATEMENT.** If the renewal premium is not paid before the Grace Period ends, the Policy will lapse as of the Renewal Date. After the Policy lapses, if we accept premium but do not require a completed application for reinstatement, we will reinstate this Policy effective on the date we accept the premium. If we require an application for reinstatement and such application is approved by the Home Office, the Policy will be reinstated as of the approval date. A fully completed application of the form then in use by the Company will be deemed approved on the 45th day after the date we receive the application, unless we have previously sent written notice of our disapproval.

If the Policy is reinstated, the reinstatement application will be subject to the "Incontestable" provision from the effective date of reinstatement, and we will pay benefits only for a covered condition that is First Manifested and First Occurs after the 10th day following the reinstatement approval date. For purposes of any riders, the reinstated coverage will cover only: (1) loss from Injury sustained after the reinstatement approval date; or (2) Sickness that is First Manifested and First Occurs after the 10th day following the reinstatement approval date. Except for any conditions added because of reinstatement, both the Owner's right and ours will be the same as before the Policy or any rider lapsed.

## CLAIM PROVISIONS

**NOTICE OF CLAIM.** Written notice of claim must be given to us within 90 days after a covered loss starts or as soon thereafter as reasonably possible. However, except in the absence of legal capacity, written notice of claim must be furnished to the Home Office not later than 12 months after a covered loss starts. Notice should include the full name of the Insured and the Policy number. Providing a proper notice of claim within the provisions contained in this Policy is an express condition precedent to any claim payment. Failure to submit a notice of claim within these provisions will be deemed prejudicial to us. ***WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of a felony.***

**CLAIM FORMS.** When we receive written notice of claim, we will send claim forms for filing proof of loss. If these forms are not sent within 15 days after we receive a proper notice of claim, the initial proof of loss requirements will be met by giving us a written statement of the nature and extent of the loss. We must receive this statement within the time limit stated in the "Proof of Loss" provision.

**PROOF OF LOSS.** As an express condition precedent to receiving any benefit under this Policy, written proof of loss must be furnished to us within 90 days after the covered loss starts. Failure to furnish such proof within 90 days shall not invalidate or reduce any claim if it was not reasonably possible to provide proof of loss within such time. However, except in the absence of legal capacity, proof must be furnished as soon as reasonably possible and in no event later than 12 months from the time the covered loss starts. Failure to submit proof of loss within these provisions will be deemed prejudicial to us.

**AUTHORIZATION TO OBTAIN MEDICAL INFORMATION.** If necessary to determine our liability, as part of proof of loss, we may require: (1) proof of eligibility; (2) itemized bills stating the extent of loss; and (3) other

information that might affect our liability. We may request your authorization for release of medical data from providers of medical services and from other sources. If any information is not furnished or the release of data is not authorized, we reserve the right to deny the claim.

**TIMEFRAME FOR PAYMENT OF CLAIMS.** Benefits payable under this Policy will be paid as soon as we receive proper notice of claim and complete written proof of loss within the provisions of this Policy. You may be required to submit additional proof of your continuing Total Disability to receive any payment after the first payment.

**PAYMENT OF CLAIMS.** We will pay all benefits to the Owner. If the Company reasonably believes that it faces a possibility of competing claims for the Policy proceeds, it will be permitted to interplead the Policy proceeds into a court's registry. Such action is not to be construed as a breach of contract or bad faith. Unless prohibited by law, the Company may offset the Policy proceeds for any expenses incurred in relation to this judicial proceeding.

**UNPAID PREMIUM**. When a claim is paid, any premium due and unpaid may be deducted by the Company from the claim payment.

**CLAIM APPEAL PROCESS.** Our practice is to treat each claim submission fairly based on the facts we are provided. We will inform the Owner if a claim or any part of a claim is denied. The Owner may have additional information that could change a claim decision. If the Owner believes that our decision was made in error, he/she may request the re-evaluation of the claim. The request for re-evaluation must be in writing and should include the names, addresses and telephone numbers of any treating Physicians or facilities that provided care or treatment. The request must be sent to us within three years of the earlier of the time written proof of loss was filed or should have been provided to us. After we re-evaluate the claim, we will notify the Owner of our decision in writing. Any benefits due as a result of our re-evaluation will be paid in accordance with the "Timeframe for Payment of Claims" provision.

**PHYSICAL EXAMINATION AND AUTOPSY.** At our expense, we have the right to have the Insured examined as often as reasonably necessary while a claim is pending. Where it is not prohibited by law, we may require an autopsy when death occurs. We also reserve the right to have a Physician of our choice and at our expense review the medical records to confirm any diagnosis, whether or not death has occurred.

## GENERAL PROVISIONS

**ASSIGNMENT.** Benefits provided by this Policy may not be assigned.

**CONFORMITY WITH STATE STATUTES.** Any provision of this Policy which is in conflict with the laws of the state in which the Application for this Policy was signed is amended to conform to the minimum requirements of such state's laws.

**CONTACT INFORMATION.** The Owner is responsible for notifying the Company of a change of address or telephone number for any party relevant to this Policy (e.g., Owner, Insured, Policy payor, etc.). Failure to ensure that the Company has the correct telephone number or address may result in a delay or inability to receive premium notices, general correspondence, or other important information regarding this Policy. If the Owner fails to submit and/or maintain current contact information on file with the Company, we will not be responsible for any information not received.

**DUPLICATE POLICY REQUEST**. At the request of the Owner, we will provide a copy of the insurance Policy. An administrative fee may be charged for this service. By ordering a duplicate Policy, the Owner is attesting that the Policy has been lost or destroyed, and the Policy has not been assigned, hypothecated, or pledged in any

way without previously notifying the Company. If the original Policy is found, the Owner agrees to return the duplicate policy to us, our successors, or our assignees.

**ENTIRE CONTRACT; CHANGES.** This Policy is a legal contract between the Company and the Owner. The contract is comprised of: (1) this Policy; (2) the initial Application (a copy of which is attached to and made a part of this Policy); (3) any later applications which we may require for increases in benefits, additional riders, or reinstatement; (4) any riders attached to this Policy; (5) any endorsements or amendments attached to this Policy; and (6) the payment of the first premiums as specified in this Policy.

Any additional rider attached to this Policy will become a part of this Policy and will be subject to all the terms and conditions of this Policy (unless we state otherwise in writing). Any statement made in the Application(s) by or on behalf of the Insured will be (in the absence of fraud) considered a representation and not a warranty. Any written or recorded verbal statement made in or about the Application(s) may be used to deny a claim or void this Policy (subject to the "Incontestable" provision).

In order to become effective, any change or waiver of the Policy terms must be: (1) in writing; (2) signed by our President, Vice President or Secretary; and (3) endorsed on this Policy. Only these individuals have the authority to change, amend, or waive any provision of this contract.

**INCONTESTABLE.** After this Policy has been in force for a period of three years during the Insured's lifetime (excluding any period during which the Insured is disabled) or three years after the date of reinstatement (if later), the Policy shall become incontestable as to the statements contained in the Application except for fraudulent misstatements. If the Owner applies and is approved for an increase in benefits under this Policy or addition of a rider to this Policy, the increase in benefits shall become incontestable as to the statements contained in the application for increase in benefits after three years from the date of such application except for fraudulent misstatements.

**LEGAL ACTION.** No legal action may be brought to recover on this Policy: (1) unless notice of claim and proof of loss was provided to us within the provisions contained in this Policy; (2) within 60 days after written proof of loss has been given as required by this Policy; or (3) after three years from the earlier of when written proof of loss was or should have been provided to us.

**MISSTATEMENT OF AGE OR OCCUPATIONAL GROUP.** If the Insured's age or Occupational Group has been misstated or misrepresented on the Application, we will pay only such amount of benefits as the premium paid would have purchased at the correct age and Occupational Group. If the Insured would not have been eligible for coverage, any premiums paid will be refunded and the Policy voided retroactive to the Coverage Effective Date.

**NONPARTICIPATION.** This Policy shall not participate in any surplus of the Company.

**OWNERSHIP**. The Owner may exercise and enjoy all rights hereunder. These rights include: assigning his Policy; changing ownership; increasing or decreasing benefits (within the Company's then current guidelines); and exercising all Policy options.

**SUCCESSION OF OWNERSHIP**. In the event of the Owner's death, the rights of ownership shall pass to the estate of the deceased Owner. Alternatively, the Owner may name a contingent owner in writing if the Owner submits a written request which is: (1) submitted prior to the death of the Owner; (2) received and approved by the Home Office; and (3) recorded in the books and records of the Home office. This would allow the rights of ownership to pass to the contingent owner upon the death of the Owner.

# NATIONAL TEACHERS ASSOCIATES LIFE INSURANCE COMPANY

**DISABILITY INCOME INSURANCE POLICY – SERIES IV**

KEEP THIS FORM FOR YOUR RECORDS

# NATIONAL TEACHERS ASSOCIATES LIFE INSURANCE COMPANY

P. O. BOX 802207 ● DALLAS, TEXAS 75380 ● (888) 671-6771

## OUTLINE OF COVERAGE

For Disability Income Protection Coverage Policy Series GRD-6004-AR **(9/10)**

**(1)** This outline of coverage provides a very brief description of some of the important features of your Policy. All capitalized words are defined in the Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and the Company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY.**

**(2)** Disability income protection coverage is designed to provide you with benefits for losses resulting from a covered Injury or Sickness. Coverage is provided as outlined in paragraph (3). The benefits described in paragraph (3) may be limited by paragraph (4).

## (3) BENEFITS

**Policy GRD-6004-AR (9/10)** We will pay the benefits summarized below if you are Totally Disabled due to a covered Injury occurring or Sickness first manifested after the Issue Date and while this Policy is in force.

| | |
|---|---|
| Benefits are paid after the elimination period shown in the Policy Schedule up to the maximum benefit period of continuous Total Disability as elected on the application. | |
| ***BENEFITS BEFORE AGE 70 IF GAINFULLY EMPLOYED*** | |
| **A. TOTAL DISABILITY MONTHLY BENEFIT - INJURY** | **$[2,500]** |
| **B. TOTAL DISABILITY MONTHLY BENEFIT - SICKNESS** | **$[2,500]** |
| **C. HOSPITAL DISABILITY MONTHLY BENEFIT - INJURY OR SICKNESS** | **$[2,500]** |
| **D. PHYSICIAN CONSULTATION BENEFIT** (maximum two visits per calendar year) | **$[75]** |
| **E. AMBULANCE EXPENSE BENEFIT** | |
| Air Ambulance (maximum two trips per calendar year) | **$[1,250]** |
| Ground Ambulance (maximum two trips per calendar year) | **$[625]** |
| **F. WAIVER OF PREMIUM** (after 60 days of continuous Total Disability) | |
| ***BENEFITS AGE 70 AND AFTER OR WHILE NOT GAINFULLY EMPLOYED*** | |
| **A. HOSPITAL DISABILITY MONTHLY BENEFIT - INJURY OR SICKNESS** | **$[5,000]** |
| **B. CONVALESCENCE MONTHLY BENEFIT - INJURY OR SICKNESS** (payable for same number of months or partial months as Hospital Disability) | **$[2,500]** |
| **C. PHYSICIAN CONSULTATION BENEFIT** (maximum two visits per calendar year) | **$[75]** |
| **D. AMBULANCE EXPENSE BENEFIT** | |
| Air Ambulance (maximum two trips per calendar year) | **$[1,250]** |
| Ground Ambulance (maximum two trips per calendar year) | **$[625]** |
| **E. WAIVER OF PREMIUM** (after 60 days of continuous Hospital Disability) | |

## (4) EXCLUSIONS AND LIMITATIONS

The Policy provides benefits only for loss resulting from a covered Injury or Sickness which occurs while the Policy is in force. The Policy does not provide policy benefits for loss if your Injury or Sickness is caused or contributed to by:

1. preexisting conditions as defined below;

2. attempted suicide or intentionally self-inflicted Injury, while sane or insane;

3. war or any act of war, whether declared or undeclared;

4. participation in a riot or civil commotion;

5. active duty status in the armed forces (if you notify us of such active duty, the Policy will lapse and we will refund any premiums paid for any period for which no coverage is provided as a result of this exclusion);

6. the voluntary use or taking of any narcotic, barbiturate, controlled substance, or other drug (unless taken or used as prescribed by a physician); or the medical treatment of these acts;

7. the voluntary taking, absorption, or inhalation of any poison, gas or fumes; or medical treatment of any of these acts;

8. Injury resulting from alcohol, an intoxicant, or being under the influence of alcohol or an intoxicant;

9. Injury while you are acting a pilot or crew member in any aircraft; while a passenger in aircraft operated by the armed forces or used for training, practice, tests, experimental or exhibition or stunt purposes; or while a passenger (other than a fare-paying passenger) in any aircraft;

10. the commission or attempted commission of an assault, battery and/or felony; or being engaged in an illegal occupation;

11. incarceration in a municipal, county, state or federal correctional facility;

12. medical treatment or an elective procedure that is not medically necessary, including, but not limited to, cosmetic surgery; or

13. child birth or pregnancy (except for Complications of Pregnancy) if the Total Disability begins within the first 300 days after the Coverage Effective Date.

**We will not pay concurrent benefits for multiple Injuries or Sicknesses which occur at the same time during a Total Disability.**

**Preexisting Conditions Limitation.** The Policy and any attached riders do not cover Total Disability or Hospital Confinement resulting from preexisting conditions for the one year period after the Coverage Effective Date. Preexisting condition means a condition (whether known or unknown) for which medical advice or treatment was recommended by or received from a Physician within the one-year period before the Coverage Effective Date, or for which symptoms existed within the one-year period before the Coverage Effective Date that would cause an ordinarily prudent person to seek diagnosis, care, or treatment (whether or not such advice or treatment was actually sought or received).

## (5) RENEWABILITY

The Policy is guaranteed renewable for life if the premiums are paid when due or within the Grace Period. If the premiums are paid on time, we cannot cancel the Policy or place any restrictions on it. Renewal premiums will be at the premium rates in effect on the Renewal Date.

## (6) PREMIUMS

The first premium is due before we issue the Policy. The Policy may be continued to the next Renewal Date by timely payment of premium. All premiums are to be paid to us, and are due in advance of the period they are to cover. This Policy has a 31-day Grace Period in which to pay the premium. During the Grace Period, the Policy will stay in force. Premiums are subject to change. If we do change the premium rates, we will do so only if we change the premium rates for all policies in the same class and in the same state as this Policy.

**NATIONAL TEACHERS ASSOCIATES LIFE INSURANCE COMPANY**
P.O. Box 802207, Dallas, Texas 75380
Phone (888) 671-6771 Fax (972) 532-2180

**Check if applicable:**
☐ Name Change
☐ Policy Reinstatement
☐ Plan Change:
Policy #_____
☐ Other _____

# APPLICATION FOR DISABILITY INCOME AND/OR SIMPLETERM™ LIFE INSURANCE

APPLICANT: Please supply all of the following important information. It will be used to determine your eligibility for coverage, including age, height, weight, occupation, and responses to medical information below.

| Name of Proposed Primary Insured (Last, First, Middle Initial) | | | | | Social Security No. - - |
|---|---|---|---|---|---|
| Sex | Date of Birth | Age (Maximum 64) | Height | Weight | (For Statistics Only) ☐Smoker ☐Non-Smoker |
| Address | | | | | E-mail Address |
| City | County or Parish | State | Zip - | CODES | St. / Cnty. / City / Bldg. |
| Home Phone ( ) | Work Phone ( ) | | Cell Phone ( ) | | |
| Best place and time to call (before 5 pm) ☐HM ☐WK ☐CELL / ☐AM_____ ☐PM_____ | School System | | School or Business | | |
| Current Annual Pre-tax Income $ | Occupation (Min. 30 hrs./week required for disability coverages) | | Occupational Group | | |

| Primary Death Benefit Beneficiary | Relationship | Contingent Death Benefit Beneficiary | Relationship |
|---|---|---|---|
| Address | Date of Birth | Address | Date of Birth |

☐ Application for Disability Income Policy

| Monthly Disability Applied For $ | Elimination Period (days) Injury ____ Sickness____ | Max. Benefit Period (months) Injury ____ Sickness____ | Optional Riders: ☐Hosp. Inpatient $_____ / day ☐Other _____ |
|---|---|---|---|

☐ Application for SimpleTerm™ Life Insurance Policy

| ☐ Term Life Face Amount Applied for $_____ | ☐ $5,000 Child Rider Face Amount | ☐ AD&D Rider Face Amount $_____ |
|---|---|---|

| FOR CHILD LIFE INSURANCE RIDER | Names of Dependent Children (Last, First, Middle) (use additional paper if necessary) | Social Security No. | Birthdate | Sex |
|---|---|---|---|---|
| | | | | |

| ☐ Owner and/or ☐ Payor of Policy if Other than Proposed Insured | Relationship | Address | |
|---|---|---|---|
| City | State | Zip | Social Security Number |

**COVERAGE WILL BE AUTOMATICALLY DECLINED FOR ANY "YES" RESPONSE TO QUESTIONS 1-3.**

1. ☐ No ☐ Yes Are you currently **not working** because of sickness or an injury; **on leave** from work; **disabled**; or **under the care of a hospital, long term care facility, or nursing home**?
2. ☐ No ☐ Yes Within the past 10 years, have you been **prescribed insulin** or **insulin refills**; or have you **ever** been diagnosed with **Type I diabetes**?
3. Within the past 10 years, have you: (i) **had symptoms of**, (ii) **received medical advice for**, (iii) **been diagnosed with**, (iv) **received treatment or surgery for**, or (v) **been prescribed medication for**:
   - ☐ No ☐ Yes a. **Cancer** (including internal / in situ / melanoma Cancer, but excluding other skin cancers)?
   - ☐ No ☐ Yes b. Any disease, disorder, or abnormality of the **cardiovascular system or heart,** such as coronary artery disease, heart disease, heart attack, diagnostic heart catheterization, or any heart surgery (excluding: mitral valve prolapse; heart murmur; and an irregular heartbeat not treated with medication or surgery)?



A

**I have reviewed all responses provided in this application for accuracy.** _____ Initial

☐ No ☐ Yes c. Any disease, disorder, or abnormality of the **circulatory system** (including arteries, veins, vessels, and lymph nodes; excluding high blood pressure if controlled)?

☐ No ☐ Yes d. **Stroke**, **transient ischemic attack** (TIA or mini-stroke), or any disease of the **brain**?

☐ No ☐ Yes e. **Kidney** (renal) **failure or insufficiency**, **liver failure**, or **cirrhosis** of the liver?

☐ No ☐ Yes f. **Emphysema** or chronic obstructive pulmonary disease (**COPD**)?

☐ No ☐ Yes g. **Psychosis** (including schizophrenia, manic depression (bipolar), and severe/major depression)?

☐ No ☐ Yes h. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for antibodies to the AIDS virus (**HIV positive**)?

4. ☐ No ☐ Yes In the past 3 years, have you been hospitalized or undergone surgery for any disease, disorder, or abnormality of the **back, neck, spine, bones, or joints** (including rheumatoid arthritis**,** osteoarthritis or degenerative joint disease)? If yes, explain: _____.
5. Name, city, and phone number of your primary care physician: _____.
6. ☐ No ☐ Yes Is the policy for which you are applying intended to replace or change any of your existing policies? If yes, identify type (disability or life), company, and benefit amount: _____ $_____.
7. ☐ Yes I understand that the disability income coverage for which I may be applying does not provide benefits for loss attributable to preexisting medical conditions for 1 year after the Issue Date.
8. ☐ No ☐ Yes I request a delayed Issue Date of _____ for my disability income policy and agree that preexisting conditions will be determined as of the delayed Issue Date.

## MODE OF PAYMENT

**Initial Premium with Application:** ☐ Check Attached * ☐ Credit Card Payment ☐ Other _____

**Recurring Payments:** ☐ **Monthly** ☐ **Other** _____ ☐ Bank Draft ☐ Credit Card ☐ Payroll Deduction ☐ Other_____

Policy and Optional Riders:
Life Ins. $ _____
Disability Ins. $ _____
Total Premium $ _____

* When a check is provided as a payment, National Teachers Associates Life Insurance Company (NTA) may use the information from the check to make a one-time electronic funds transfer (EFT) from your account or to process the payment as a check transaction. If we use information from the check to make an EFT, funds may be withdrawn from your account the same day that NTA receives your check. You may not receive the cancelled check from your financial institution.

## BANK DRAFT AUTHORIZATION

**USE ACCOUNT INFO. FROM:** ☐Initial Premium Check **OR** ☐Specimen Check (attached)

I request and authorize National Teachers Associates Life Insurance Company to make withdrawals against the bank account selected above, or any account subsequently named by me, and such bank(s) to process these withdrawals as if I had signed them for the purpose of collecting premiums under the policy. If the said account is replaced by an account in another bank, this request and authorization shall also apply to such other bank. I understand that I have the right to receive notice of each electronic debit entry that varies in amount from the previous entry, but I elect to receive such notice only when such entry differs from the previous entry by more than $200.

X _____ _____/_____/_____
Signature exactly as it appears on bank records — Date Signed

Requested first draft date (1-28 only)

***WARNING:*** **Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

I, (or we) certify that I have read or had read to me the completed application and submit it as my offer for the purchase of insurance. I understand that I have no coverage unless and until the policy is issued by the Company. I represent that the answers are true and correct and realize that any fraudulent statement or material misrepresentation in the application may result in a loss of coverage. I authorize the Company to call me on a recorded phone call to clarify or verify certain information in this application and agree that a transcript of such recording can be made a part of my application for insurance. No oral statement between the agent and me will be binding on the Company. No person to be covered under this policy is currently receiving benefits under Medicare or Medicaid. A copy of this application will be valid as if it were an original. I agree to be bound by the Arbitration Program for the resolution of disputes under the Federal Arbitration Act if included in any policy for which I am applying. I also certify that I have received a copy of the Company's privacy notice and privacy practices.

DATED AT _____ (City and State), THIS _____ (Day) DAY OF _____ (Month) _____ (Year)

X _____
Signature of Proposed Primary Insured

X _____
Signature of Owner/Payor if other than Proposed Primary Insured

I certify that I have truly and accurately recorded on this Application the information supplied by the applicant.

_____ Licensed Agent Signature | _____ Printed agent name | _____ License ID No. | _____ Agent No.

**4949 Keller Springs Road, Addison, TX 75001** Address | **1-800-TALK-NTA** Phone

**National Teachers Associates Life Insurance Company**
4949 Keller Springs Road • Addison, Texas 75001 • (888) 671-6771

# Authorization for Release of Health-Related Information

**This Authorization Complies with HIPAA Privacy Rule**

By executing this Authorization, I authorize all health care providers that have been involved in my care, diagnosis or treatment (including, but not limited to, physicians, hospitals, clinics, medical practitioners, and other medically related facilities) to disclose my medical records (including, but not limited to, patient histories, progress notes, test results, x-rays and other diagnostic information) to employees of National Teachers Associates Life Insurance Company and affiliated entities involved in determining eligibility for an insurance policy or processing a claim. This Authorization may be required to obtain an insurance policy or to determine eligibility for benefits.

National Teachers Associates Life Insurance Company and affiliated entities may disclose my medical records and the information contained in those medical records to business associates, affiliated third parties, or other organizations (such as reinsurers), for the purposes stated above and as permitted by law. I also understand that when my medical records and the information contained in those medical records are disclosed pursuant to this Authorization, they may be re-disclosed and may no longer be protected by federal privacy laws.

I understand that I may revoke this Authorization in writing, except to the extent that National Teachers Associates Life Insurance Company or an affiliated entity has acted in reliance upon this Authorization. My revocation **in writing** must be submitted to:

National Teachers Associates Life Insurance Company
Attn: Director of Compliance
4949 Keller Springs Road • Addison, Texas 75001

This Authorization will expire two (2) years from the date that this Authorization is signed.

I understand that I have the right to a copy of this Authorization and I agree that a copy of this Authorization is as valid as the original.

_____ _____
Signature of Individual Whose Information is to be Disclosed Date

_____ _____
Printed Name of Individual Policy Number

H

NTA

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *NTAL-126849910* | *State:* | *Arkansas* |
| *Filing Company:* | *National Teachers Associates Life Insurance Company* | *State Tracking Number:* | *47062* |
| *Company Tracking Number:* | *GRD-6004-AR (9/10)* | | |
| *TOI:* | *H11I Individual Health - Disability Income* | *Sub-TOI:* | *H11I.004 Other* |
| *Product Name:* | *Disability Income 4* | | |
| *Project Name/Number:* | */* | | |

# Supporting Document Schedules

| | | Item Status: | Status Date: |
|---|---|---|---|
| **Satisfied - Item:** | Flesch Certification | Approved-Closed | 10/28/2010 |

**Comments:**

**Attachments:**

Read Cert.pdf

Reg 19.pdf

| | | Item Status: | Status Date: |
|---|---|---|---|
| **Satisfied - Item:** | Application | Approved-Closed | 10/28/2010 |

**Comments:**

**Attachments:**

75-401 (9.10).pdf

75-401 (9.10) John Doe.pdf

| | | Item Status: | Status Date: |
|---|---|---|---|
| **Satisfied - Item:** | Outline of Coverage | Approved-Closed | 10/28/2010 |

**Comments:**

**Attachment:**

GRD-6004-AR.OC (9.10).pdf

| | | Item Status: | Status Date: |
|---|---|---|---|
| **Satisfied - Item:** | Cover Letter | Approved-Closed | 10/28/2010 |

**Comments:**

**Attachment:**

AR DI 4 Letter.pdf

# *NATIONAL TEACHERS ASSOCIATES LIFE INSURANCE COMPANY*

4949 Keller Springs Road • Addison, Texas 75001-5910
(972) 532-2100 • Fax (972) 532-2194
*www.ntalife.com*


## ARKANSAS

I hereby certify that to the best of my knowledge and belief the following forms, according to the Flesh test, have these readability scores:

Defined terms and headings have been excluded for purposes of the calculation of the Readability score.

| FORM | FORM NO. | SCORE |
|---|---|---|
| Disability Income Insurance Policy – Series IV | GRD-6004-AR (9/10) | 54.0 |
| Application for Disability Income And/or SimpleTerm Life Ins | 75-401 (9/10) | 50.0 |
| Outline of Coverage | GRD-6004-AR.OC (9/10) | 51.0 |

Signed _____
William Bradley Cox
General Counsel and
Vice President

Date 10-15-10

# *NATIONAL TEACHERS ASSOCIATES LIFE INSURANCE COMPANY*

4949 Keller Springs Road • Addison, Texas 75001-5910
(972) 532-2100 • Fax (972) 532-2194
*www.ntalife.com*


## ARKANSAS

To the best of my knowledge, this submission meets the requirements of the Rule and Regulation 19 and the applicable requirements of the Arkansas Department of Insurance.

Signed _____
William Bradley Cox
General Counsel and
Vice President

Date 10-15-10

**NATIONAL TEACHERS ASSOCIATES LIFE INSURANCE COMPANY**
P.O. Box 802207, Dallas, Texas 75380
Phone (888) 671-6771 Fax (972) 532-2180

**Check if applicable:**
☐ Name Change
☐ Policy Reinstatement
☐ Plan Change:
Policy #_____
☐ Other _____

# APPLICATION FOR DISABILITY INCOME AND/OR SIMPLETERM™ LIFE INSURANCE

APPLICANT: Please supply all of the following important information. It will be used to determine your eligibility for coverage, including age, height, weight, occupation, and responses to medical information below.

| Name of Proposed Primary Insured (Last, First, Middle Initial) | | | | | Social Security No. - - |
|---|---|---|---|---|---|
| Sex | Date of Birth | Age (Maximum 64) | Height | Weight | (For Statistics Only) ☐Smoker ☐Non-Smoker |
| Address | | | | | E-mail Address |
| City | County or Parish | State | Zip - | CODES | St. / Cnty. / City / Bldg. |
| Home Phone ( ) | Work Phone ( ) | | Cell Phone ( ) | | |
| Best place and time to call (before 5 pm) ☐HM ☐WK ☐CELL / ☐AM_____ ☐PM_____ | School System | | School or Business | | |
| Current Annual Pre-tax Income $ | Occupation (Min. 30 hrs./week required for disability coverages) | | Occupational Group | | |

| Primary Death Benefit Beneficiary | Relationship | Contingent Death Benefit Beneficiary | Relationship |
|---|---|---|---|
| Address | Date of Birth | Address | Date of Birth |

☐ Application for Disability Income Policy

| Monthly Disability Applied For $ | Elimination Period (days) Injury ____ Sickness____ | Max. Benefit Period (months) Injury ____ Sickness____ | Optional Riders: ☐Hosp. Inpatient $_____ / day ☐Other _____ |
|---|---|---|---|

☐ Application for SimpleTerm™ Life Insurance Policy

| ☐ Term Life Face Amount Applied for $_____ | ☐ $5,000 Child Rider Face Amount | ☐ AD&D Rider Face Amount $_____ |
|---|---|---|

| FOR CHILD LIFE INSURANCE RIDER | Names of Dependent Children (Last, First, Middle) (use additional paper if necessary) | Social Security No. | Birthdate | Sex |
|---|---|---|---|---|
| | | | | |

| ☐ Owner and/or ☐ Payor of Policy if Other than Proposed Insured | Relationship | Address | |
|---|---|---|---|
| City | State | Zip | Social Security Number |

**COVERAGE WILL BE AUTOMATICALLY DECLINED FOR ANY "YES" RESPONSE TO QUESTIONS 1-3.**

1. ☐ No ☐ Yes Are you currently **not working** because of sickness or an injury; **on leave** from work; **disabled**; or **under the care of a hospital, long term care facility, or nursing home**?
2. ☐ No ☐ Yes Within the past 10 years, have you been **prescribed insulin** or **insulin refills**; or have you **ever** been diagnosed with **Type I diabetes**?
3. Within the past 10 years, have you: (i) **had symptoms of**, (ii) **received medical advice for**, (iii) **been diagnosed with**, (iv) **received treatment or surgery for**, or (v) **been prescribed medication for**:
   - ☐ No ☐ Yes a. **Cancer** (including internal / in situ / melanoma Cancer, but excluding other skin cancers)?
   - ☐ No ☐ Yes b. Any disease, disorder, or abnormality of the **cardiovascular system or heart,** such as coronary artery disease, heart disease, heart attack, diagnostic heart catheterization, or any heart surgery (excluding: mitral valve prolapse; heart murmur; and an irregular heartbeat not treated with medication or surgery)?



A

**I have reviewed all responses provided in this application for accuracy.** _____ Initial

☐ No ☐ Yes c. Any disease, disorder, or abnormality of the **circulatory system** (including arteries, veins, vessels, and lymph nodes; excluding high blood pressure if controlled)?

☐ No ☐ Yes d. **Stroke**, **transient ischemic attack** (TIA or mini-stroke), or any disease of the **brain**?

☐ No ☐ Yes e. **Kidney** (renal) **failure or insufficiency**, **liver failure**, or **cirrhosis** of the liver?

☐ No ☐ Yes f. **Emphysema** or chronic obstructive pulmonary disease (**COPD**)?

☐ No ☐ Yes g. **Psychosis** (including schizophrenia, manic depression (bipolar), and severe/major depression)?

☐ No ☐ Yes h. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for antibodies to the AIDS virus (**HIV positive**)?

4. ☐ No ☐ Yes In the past 3 years, have you been hospitalized or undergone surgery for any disease, disorder, or abnormality of the **back, neck, spine, bones, or joints** (including rheumatoid arthritis**,** osteoarthritis or degenerative joint disease)? If yes, explain: _____.
5. Name, city, and phone number of your primary care physician: _____.
6. ☐ No ☐ Yes Is the policy for which you are applying intended to replace or change any of your existing policies? If yes, identify type (disability or life), company, and benefit amount: _____ $_____.
7. ☐ Yes I understand that the disability income coverage for which I may be applying does not provide benefits for loss attributable to preexisting medical conditions for 1 year after the Issue Date.
8. ☐ No ☐ Yes I request a delayed Issue Date of _____ for my disability income policy and agree that preexisting conditions will be determined as of the delayed Issue Date.

## MODE OF PAYMENT

**Initial Premium with Application:** ☐ Check Attached * ☐ Credit Card Payment ☐ Other _____

**Recurring Payments:** ☐ **Monthly** ☐ **Other** _____ ☐ Bank Draft ☐ Credit Card ☐ Payroll Deduction ☐ Other_____

Policy and Optional Riders:
Life Ins. $ _____
Disability Ins. $ _____
Total Premium $ _____

* When a check is provided as a payment, National Teachers Associates Life Insurance Company (NTA) may use the information from the check to make a one-time electronic funds transfer (EFT) from your account or to process the payment as a check transaction. If we use information from the check to make an EFT, funds may be withdrawn from your account the same day that NTA receives your check. You may not receive the cancelled check from your financial institution.

## BANK DRAFT AUTHORIZATION

**USE ACCOUNT INFO. FROM:** ☐Initial Premium Check **OR** ☐Specimen Check (attached)

I request and authorize National Teachers Associates Life Insurance Company to make withdrawals against the bank account selected above, or any account subsequently named by me, and such bank(s) to process these withdrawals as if I had signed them for the purpose of collecting premiums under the policy. If the said account is replaced by an account in another bank, this request and authorization shall also apply to such other bank. I understand that I have the right to receive notice of each electronic debit entry that varies in amount from the previous entry, but I elect to receive such notice only when such entry differs from the previous entry by more than $200.

X _____ _____/_____/_____
Signature exactly as it appears on bank records — Date Signed

Requested first draft date (1-28 only)

***WARNING:*** **Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

I, (or we) certify that I have read or had read to me the completed application and submit it as my offer for the purchase of insurance. I understand that I have no coverage unless and until the policy is issued by the Company. I represent that the answers are true and correct and realize that any fraudulent statement or material misrepresentation in the application may result in a loss of coverage. I authorize the Company to call me on a recorded phone call to clarify or verify certain information in this application and agree that a transcript of such recording can be made a part of my application for insurance. No oral statement between the agent and me will be binding on the Company. No person to be covered under this policy is currently receiving benefits under Medicare or Medicaid. A copy of this application will be valid as if it were an original. I agree to be bound by the Arbitration Program for the resolution of disputes under the Federal Arbitration Act if included in any policy for which I am applying. I also certify that I have received a copy of the Company's privacy notice and privacy practices.

DATED AT _____ (City and State), THIS _____ (Day) DAY OF _____ (Month) _____ (Year)

X _____
Signature of Proposed Primary Insured

X _____
Signature of Owner/Payor if other than Proposed Primary Insured

I certify that I have truly and accurately recorded on this Application the information supplied by the applicant.

_____ Licensed Agent Signature | _____ Printed agent name | _____ License ID No. | _____ Agent No.

**4949 Keller Springs Road, Addison, TX 75001** Address | **1-800-TALK-NTA** Phone

**National Teachers Associates Life Insurance Company**
4949 Keller Springs Road • Addison, Texas 75001 • (888) 671-6771

# Authorization for Release of Health-Related Information

**This Authorization Complies with HIPAA Privacy Rule**

By executing this Authorization, I authorize all health care providers that have been involved in my care, diagnosis or treatment (including, but not limited to, physicians, hospitals, clinics, medical practitioners, and other medically related facilities) to disclose my medical records (including, but not limited to, patient histories, progress notes, test results, x-rays and other diagnostic information) to employees of National Teachers Associates Life Insurance Company and affiliated entities involved in determining eligibility for an insurance policy or processing a claim. This Authorization may be required to obtain an insurance policy or to determine eligibility for benefits.

National Teachers Associates Life Insurance Company and affiliated entities may disclose my medical records and the information contained in those medical records to business associates, affiliated third parties, or other organizations (such as reinsurers), for the purposes stated above and as permitted by law. I also understand that when my medical records and the information contained in those medical records are disclosed pursuant to this Authorization, they may be re-disclosed and may no longer be protected by federal privacy laws.

I understand that I may revoke this Authorization in writing, except to the extent that National Teachers Associates Life Insurance Company or an affiliated entity has acted in reliance upon this Authorization. My revocation **in writing** must be submitted to:

National Teachers Associates Life Insurance Company
Attn: Director of Compliance
4949 Keller Springs Road • Addison, Texas 75001

This Authorization will expire two (2) years from the date that this Authorization is signed.

I understand that I have the right to a copy of this Authorization and I agree that a copy of this Authorization is as valid as the original.

_____ _____
Signature of Individual Whose Information is to be Disclosed Date

_____ _____
Printed Name of Individual Policy Number

H

NTA

**NATIONAL TEACHERS ASSOCIATES LIFE INSURANCE COMPANY**
P.O. Box 802207, Dallas, Texas 75380
Phone (888) 671-6771 Fax (972) 532-2180

**Check if applicable:**
☐ Name Change
☐ Policy Reinstatement
☐ Plan Change:
Policy #_____
☐ Other _____

# APPLICATION FOR DISABILITY INCOME AND/OR SIMPLETERM™ LIFE INSURANCE

APPLICANT: Please supply all of the following important information. It will be used to determine your eligibility for coverage, including age, height, weight, occupation, and responses to medical information below.

| Name of Proposed Primary Insured (Last, First, Middle Initial) | Social Security No. |
|---|---|
| Doe, John A | 123 - 45 - 6789 |

| Sex | Date of Birth | Age (Maximum 64) | Height | Weight | (For Statistics Only) |
|---|---|---|---|---|---|
| M | 1-1-74 | 36 | 6'2" | 190 | ☐Smoker ☒Non-Smoker |

| Address | E-mail Address |
|---|---|
| 123 Main | J.Doe@Yahoo.com |

| City | County or Parish | State | Zip | CODES | St. | Cnty. | City | Bldg. |
|---|---|---|---|---|---|---|---|---|
| Dallas | Dallas | TX | 75000 - | | | | | |

| Home Phone | Work Phone | Cell Phone |
|---|---|---|
| (214) 861-5309 | (214) 861-5309 | (214) 861-5309 |

| Best place and time to call (before 5 pm) | School System | School or Business |
|---|---|---|
| ☐HM ☒WK ☐CELL / ☒AM 9 ☐PM____ | ISD | Carter |

| Current Annual Pre-tax Income | Occupation (Min. 30 hrs./week required for disability coverages) | Occupational Group |
|---|---|---|
| $ 45,000 | Teacher | I |

| Primary Death Benefit Beneficiary | Relationship | Contingent Death Benefit Beneficiary | Relationship |
|---|---|---|---|
| Jane A Doe | wife | | |
| **Address** | **Date of Birth** | **Address** | **Date of Birth** |
| 123 Main | 1-1-77 | | |

☒ Application for Disability Income Policy

| Monthly Disability Applied For | Elimination Period (days) | Max. Benefit Period (months) | Optional Riders: |
|---|---|---|---|
| $ 10,000 | Injury 7 Sickness 7 | Injury 6 Sickness 6 | ☐Hosp. Inpatient $_____ / day ☐Other _____ |

☐ Application for SimpleTerm™ Life Insurance Policy

| ☐ Term Life Face Amount Applied for | ☐ $5,000 Child Rider Face Amount | ☐ AD&D Rider Face Amount |
|---|---|---|
| $_____ | | $_____ |

| FOR CHILD LIFE INSURANCE RIDER | Names of Dependent Children (Last, First, Middle) (use additional paper if necessary) | Social Security No. | Birthdate | Sex |
|---|---|---|---|---|
| | | | | |

| ☐ Owner and/or ☐ Payor of Policy if Other than Proposed Insured | Relationship | Address |
|---|---|---|
| | | |

| City | State | Zip | Social Security Number |
|---|---|---|---|
| | | | |

**COVERAGE WILL BE AUTOMATICALLY DECLINED FOR ANY "YES" RESPONSE TO QUESTIONS 1-3.**

1. ☒ No ☐ Yes Are you currently **not working** because of sickness or an injury; **on leave** from work; **disabled**; or **under the care of a hospital, long term care facility, or nursing home**?
2. ☒ No ☐ Yes Within the past 10 years, have you been **prescribed insulin** or **insulin refills**; or have you **ever** been diagnosed with **Type I diabetes**?
3. Within the past 10 years, have you: (i) **had symptoms of**, (ii) **received medical advice for**, (iii) **been diagnosed with**, (iv) **received treatment or surgery for**, or (v) **been prescribed medication for**:
   - ☒ No ☐ Yes a. **Cancer** (including internal / in situ / melanoma Cancer, but excluding other skin cancers)?
   - ☒ No ☐ Yes b. Any disease, disorder, or abnormality of the **cardiovascular system or heart,** such as coronary artery disease, heart disease, heart attack, diagnostic heart catheterization, or any heart surgery (excluding: mitral valve prolapse; heart murmur; and an irregular heartbeat not treated with medication or surgery)?



A

**I have reviewed all responses provided in this application for accuracy.** _____ Initial

☑ No ☐ Yes c. Any disease, disorder, or abnormality of the **circulatory system** (including arteries, veins, vessels, and lymph nodes; excluding high blood pressure if controlled)?

☑ No ☐ Yes d. **Stroke, transient ischemic attack** (TIA or mini-stroke), or any disease of the **brain**?

☑ No ☐ Yes e. **Kidney** (renal) **failure or insufficiency, liver failure**, or **cirrhosis** of the liver?

☑ No ☐ Yes f. **Emphysema** or chronic obstructive pulmonary disease (**COPD**)?

☑ No ☐ Yes g. **Psychosis** (including schizophrenia, manic depression (bipolar), and severe/major depression)?

☑ No ☐ Yes h. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for antibodies to the AIDS virus (**HIV positive**)?

4. ☑ No ☐ Yes In the past 3 years, have you been hospitalized or undergone surgery for any disease, disorder, or abnormality of the **back, neck, spine, bones, or joints** (including rheumatoid arthritis, osteoarthritis or degenerative joint disease)? If yes, explain: _____.

5. Name, city, and phone number of your primary care physician: John C Doe 214-123-4567.

6. ☑ No ☐ Yes Is the policy for which you are applying intended to replace or change any of your existing policies? If yes, identify type (disability or life), company, and benefit amount:
_____ $_____.

7. ☑ Yes I understand that the disability income coverage for which I may be applying does not provide benefits for loss attributable to preexisting medical conditions for 1 year after the Issue Date.

8. ☑ No ☐ Yes I request a delayed Issue Date of _____ for by disability income policy and agree that preexisting conditions will be determined as of the delayed Issue Date.

## MODE OF PAYMENT

**Initial Premium with Application:** ☐ Check Attached * ☐ Credit Card Payment ☐ Other _____

**Recurring Payments:** ☐ **Monthly** ☐ Bank Draft ☐ Payroll Deduction ☐ **Other** _____ ☐ Credit Card ☐ Other _____

Policy and Optional Riders:
Life Ins. $ _____
Disability Ins. $ _____
Total Premium $ _____

* When a check is provided as a payment, National Teachers Associates Life Insurance Company (NTA) may use the information from the check to make a one-time electronic funds transfer (EFT) from your account or to process the payment as a check transaction. If we use information from the check to make an EFT, funds may be withdrawn from your account the same day that NTA receives your check. You may not receive the cancelled check from your financial institution.

## BANK DRAFT AUTHORIZATION

**USE ACCOUNT INFO. FROM:** ☐ Initial Premium Check **OR** ☐ Specimen Check (attached)

I request and authorize National Teachers Associates Life Insurance Company to make withdrawals against the bank account selected above, or any account subsequently named by me, and such bank(s) to process these withdrawals as if I had signed them for the purpose of collecting premiums under the policy. If the said account is replaced by an account in another bank, this request and authorization shall also apply to such other bank. I understand that I have the right to receive notice of each electronic debit entry that varies in amount from the previous entry, but I elect to receive such notice only when such entry differs from the previous entry by more than $200.

X John A Doe
Signature exactly as it appears on bank records

10 / 1 / 10
Date Signed

Requested first draft date (1-28 only): 15

***WARNING:*** **Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

I, (or we) certify that I have read or had read to me the completed application and submit it as my offer for the purchase of insurance. I understand that I have no coverage unless and until the policy is issued by the Company. I represent that the answers are true and correct and realize that any fraudulent statement or material misrepresentation in the application may result in a loss of coverage. I authorize the Company to call me on a recorded phone call to clarify or verify certain information in this application and agree that a transcript of such recording can be made a part of my application for insurance. No oral statement between the agent and me will be binding on the Company. No person to be covered under this policy is currently receiving benefits under Medicare or Medicaid. A copy of this application will be valid as if it were an original. I agree to be bound by the Arbitration Program for the resolution of disputes under the Federal Arbitration Act if included in any policy for which I am applying. I also certify that I have received a copy of the Company's privacy notice and privacy practices.

DATED AT Dallas TX (City and State), THIS 1 (Day) DAY OF Oct (Month) 2010 (Year)

X John A Doe
Signature of Proposed Primary Insured

X _____
Signature of Owner/Payor if other than Proposed Primary Insured

I certify that I have truly and accurately recorded on this Application the information supplied by the applicant.

John F Doe — Licensed Agent Signature
John F Doe — Printed agent name
111-1 — License ID No.
111 — Agent No.
4949 Keller Springs Road, Addison, TX 75001 — Address
1-800-TALK-NTA — Phone

**National Teachers Associates Life Insurance Company**
4949 Keller Springs Road • Addison, Texas 75001 • (888) 671-6771

# Authorization for Release of Health-Related Information

**This Authorization Complies with HIPAA Privacy Rule**

By executing this Authorization, I authorize all health care providers that have been involved in my care, diagnosis or treatment (including, but not limited to, physicians, hospitals, clinics, medical practitioners, and other medically related facilities) to disclose my medical records (including, but not limited to, patient histories, progress notes, test results, x-rays and other diagnostic information) to employees of National Teachers Associates Life Insurance Company and affiliated entities involved in determining eligibility for an insurance policy or processing a claim. This Authorization may be required to obtain an insurance policy or to determine eligibility for benefits.

National Teachers Associates Life Insurance Company and affiliated entities may disclose my medical records and the information contained in those medical records to business associates, affiliated third parties, or other organizations (such as reinsurers), for the purposes stated above and as permitted by law. I also understand that when my medical records and the information contained in those medical records are disclosed pursuant to this Authorization, they may be re-disclosed and may no longer be protected by federal privacy laws.

I understand that I may revoke this Authorization in writing, except to the extent that National Teachers Associates Life Insurance Company or an affiliated entity has acted in reliance upon this Authorization. My revocation **in writing** must be submitted to:

National Teachers Associates Life Insurance Company
Attn: Director of Compliance
4949 Keller Springs Road • Addison, Texas 75001

This Authorization will expire two (2) years from the date that this Authorization is signed.

I understand that I have the right to a copy of this Authorization and I agree that a copy of this Authorization is as valid as the original.

John A Doe — 10-1-10

Signature of Individual Whose Information is to be Disclosed — Date

John A Doe — 111A-1

Printed Name of Individual — Policy Number

KEEP THIS FORM FOR YOUR RECORDS

# NATIONAL TEACHERS ASSOCIATES LIFE INSURANCE COMPANY

P. O. BOX 802207 ● DALLAS, TEXAS 75380 ● (888) 671-6771

## OUTLINE OF COVERAGE

For Disability Income Protection Coverage Policy Series GRD-6004-AR **(9/10)**

**(1)** This outline of coverage provides a very brief description of some of the important features of your Policy. All capitalized words are defined in the Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and the Company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY.**

**(2)** Disability income protection coverage is designed to provide you with benefits for losses resulting from a covered Injury or Sickness. Coverage is provided as outlined in paragraph (3). The benefits described in paragraph (3) may be limited by paragraph (4).

## (3) BENEFITS

**Policy GRD-6004-AR (9/10)** We will pay the benefits summarized below if you are Totally Disabled due to a covered Injury occurring or Sickness first manifested after the Issue Date and while this Policy is in force.

| | |
|---|---|
| Benefits are paid after the elimination period shown in the Policy Schedule up to the maximum benefit period of continuous Total Disability as elected on the application. | |
| ***BENEFITS BEFORE AGE 70 IF GAINFULLY EMPLOYED*** | |
| **A. TOTAL DISABILITY MONTHLY BENEFIT - INJURY** | **$[2,500]** |
| **B. TOTAL DISABILITY MONTHLY BENEFIT - SICKNESS** | **$[2,500]** |
| **C. HOSPITAL DISABILITY MONTHLY BENEFIT - INJURY OR SICKNESS** | **$[2,500]** |
| **D. PHYSICIAN CONSULTATION BENEFIT** (maximum two visits per calendar year) | **$[75]** |
| **E. AMBULANCE EXPENSE BENEFIT** | |
| Air Ambulance (maximum two trips per calendar year) | **$[1,250]** |
| Ground Ambulance (maximum two trips per calendar year) | **$[625]** |
| **F. WAIVER OF PREMIUM** (after 60 days of continuous Total Disability) | |
| ***BENEFITS AGE 70 AND AFTER OR WHILE NOT GAINFULLY EMPLOYED*** | |
| **A. HOSPITAL DISABILITY MONTHLY BENEFIT - INJURY OR SICKNESS** | **$[5,000]** |
| **B. CONVALESCENCE MONTHLY BENEFIT - INJURY OR SICKNESS** (payable for same number of months or partial months as Hospital Disability) | **$[2,500]** |
| **C. PHYSICIAN CONSULTATION BENEFIT** (maximum two visits per calendar year) | **$[75]** |
| **D. AMBULANCE EXPENSE BENEFIT** | |
| Air Ambulance (maximum two trips per calendar year) | **$[1,250]** |
| Ground Ambulance (maximum two trips per calendar year) | **$[625]** |
| **E. WAIVER OF PREMIUM** (after 60 days of continuous Hospital Disability) | |

## (4) EXCLUSIONS AND LIMITATIONS

The Policy provides benefits only for loss resulting from a covered Injury or Sickness which occurs while the Policy is in force. The Policy does not provide policy benefits for loss if your Injury or Sickness is caused or contributed to by:

1. preexisting conditions as defined below;

2. attempted suicide or intentionally self-inflicted Injury, while sane or insane;

3. war or any act of war, whether declared or undeclared;

4. participation in a riot or civil commotion;

5. active duty status in the armed forces (if you notify us of such active duty, the Policy will lapse and we will refund any premiums paid for any period for which no coverage is provided as a result of this exclusion);

6. the voluntary use or taking of any narcotic, barbiturate, controlled substance, or other drug (unless taken or used as prescribed by a physician); or the medical treatment of these acts;

7. the voluntary taking, absorption, or inhalation of any poison, gas or fumes; or medical treatment of any of these acts;

8. Injury resulting from alcohol, an intoxicant, or being under the influence of alcohol or an intoxicant;

9. Injury while you are acting a pilot or crew member in any aircraft; while a passenger in aircraft operated by the armed forces or used for training, practice, tests, experimental or exhibition or stunt purposes; or while a passenger (other than a fare-paying passenger) in any aircraft;

10. the commission or attempted commission of an assault, battery and/or felony; or being engaged in an illegal occupation;

11. incarceration in a municipal, county, state or federal correctional facility;

12. medical treatment or an elective procedure that is not medically necessary, including, but not limited to, cosmetic surgery; or

13. child birth or pregnancy (except for Complications of Pregnancy) if the Total Disability begins within the first 300 days after the Coverage Effective Date.

**We will not pay concurrent benefits for multiple Injuries or Sicknesses which occur at the same time during a Total Disability.**

**Preexisting Conditions Limitation.** The Policy and any attached riders do not cover Total Disability or Hospital Confinement resulting from preexisting conditions for the one year period after the Coverage Effective Date. Preexisting condition means a condition (whether known or unknown) for which medical advice or treatment was recommended by or received from a Physician within the one-year period before the Coverage Effective Date, or for which symptoms existed within the one-year period before the Coverage Effective Date that would cause an ordinarily prudent person to seek diagnosis, care, or treatment (whether or not such advice or treatment was actually sought or received).

## (5) RENEWABILITY

The Policy is guaranteed renewable for life if the premiums are paid when due or within the Grace Period. If the premiums are paid on time, we cannot cancel the Policy or place any restrictions on it. Renewal premiums will be at the premium rates in effect on the Renewal Date.

## (6) PREMIUMS

The first premium is due before we issue the Policy. The Policy may be continued to the next Renewal Date by timely payment of premium. All premiums are to be paid to us, and are due in advance of the period they are to cover. This Policy has a 31-day Grace Period in which to pay the premium. During the Grace Period, the Policy will stay in force. Premiums are subject to change. If we do change the premium rates, we will do so only if we change the premium rates for all policies in the same class and in the same state as this Policy.

# *NATIONAL TEACHERS ASSOCIATES LIFE INSURANCE COMPANY*

4949 Keller Springs Road • Addison, Texas 75001-5910
(972) 532-2100 • Fax (972) 532-2194
*www.ntalife.com*


October 15, 2010

Arkansas Department of Insurance
Life and Health Division
1200 West Third Street
Little Rock, Arkansas 72201-1904

Re: National Teachers Associates Life Insurance Company
NAIC# 87963
Federal ID # 75-1623431
Forms: GRD-6004-AR (9/10) Disability Income Insurance Policy – Series IV
GRD-6004-AR.OC (9/10) Outline of Coverage
75-401 (9/10) Application for Disability Income and/or
SimpleTerm Life Insurance

Dear Department of Insurance:

The above-referenced forms are enclosed in duplicate for your review and approval.

These forms are new and do not replace any previously approved forms. They will provide benefits for injury, sickness, or hospital confinement and other medical and professional services arising out of total disability as defined in the policy.

The policy will be marketed to individual applicants by independent agents.

These forms were filed "Exempt" by Texas, our domicile, on June 24, 2010.

We also intend to use the referenced application form with our SimpleTerm Life Insurance product, which was approved by your department on July 25, 2010.

Also enclosed is the Actuarial Memorandum with premium rates.

If you have any questions, or if you require any additional information, please call me at (800) 825-5682 extension 2156. You may also e-mail me directly at david.mather@ntalife.com.

Sincerely,

David R Mather
Compliance Analyst

enclosures